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110TH CONGRESS
2D SESSION

H. R. 6365

To amend part C of title XVIII of the Social Security Act with respect to Medicare special needs plans and the alignment of Medicare and Medicaid for dually eligible individuals.

IN THE HOUSE OF REPRESENTATIVES

JUNE 25, 2008

Mr. KIND (for himself and Mr. RAMSTAD) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend part C of title XVIII of the Social Security Act with respect to Medicare special needs plans and the alignment of Medicare and Medicaid for dually eligible individuals.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Special Needs Plans Extension and Amendments Act of 2008".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Extend SNP authority through December 31, 2012.
Sec. 3. Require targeting of high-risk groups; advance specialty care capabilities.
Sec. 4. Study on improving risk adjustment for high-risk, high-cost beneficiaries.
Sec. 5. Advance alignment of Medicare and Medicaid for dual eligibles.

SEC. 2. EXTEND SNP AUTHORITY THROUGH DECEMBER 31, 2012.

Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by section 108 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking "2010" and inserting "2013".

SEC. 3. REQUIRE TARGETING OF HIGH-RISK GROUPS; ADVANCE SPECIALTY CARE CAPABILITIES.

(a) REQUIRING TARGETING OF HIGH-RISK GROUPS.—

(1) IN GENERAL.—Section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)) is amended—

(A) in subparagraph (A), by striking all that follows "means" and inserting the following: "an MA plan—

"(i) that serves special needs individuals (as defined in subparagraph (B)); and

"(ii) for which—

"(I) at least 90 percent of the individuals enrolled after December 31, 2008, are described in subparagraph (B)(i);

"(II) at least 90 percent of the individuals enrolled after December 31, 2008, are described in subparagraph (B)(ii); or

"(III) at least 90 percent of the individuals enrolled after December 31, 2008, are described in subparagraph (B)(iii) and have a severe or disabling chronic condition of the type that the plan is committed to serve.";

(B) by adding at the end of subparagraph (A) the following: "For purposes of applying clause (ii), an individual who is described in subparagraph (B)(i) or (B)(ii) and who is enrolled in a specialized MA plan for special needs individuals shall thereafter be treated as continuing to be described in such respective subparagraph regardless of changes in the individual's circumstances so long as the individual maintains continuous enrollment in such plan. Clause (ii) shall not apply to a plan described

in section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) which was previously operated under section 2355 of the Deficit Reduction Act of 1984 (Public Law 98–369) and which is operating as a specialized MA plan for special needs individuals as of the date of the enactment of this sentence."; and

(C) in subparagraph (B)—

(i) in clause (i), by inserting "under regulations in effect as of July 1, 2007" after "as defined by the Secretary"; and

(ii) by amending clause (iii) to read as follows:

"(iii) has a severe or disabling chronic condition that requires complex care management capabilities, of the type described in subsection (f)(4), and specialized delivery systems to reduce medical complications and adverse health outcomes.".

(2) COORDINATED FINANCING FOR DUAL-ELIGIBLE SNPS.—The Secretary of Health and Human Services shall enter into agreements with States (as defined for purposes of title XIX of the Social Security Act) for coordinating the financing of special-

ized MA plans for special needs individuals described in section 1859(b)(6)(A)(ii)(II) of such Act for enrollees who are entitled to medical assistance under State plans under such title.

(b) ADVANCE SPECIALTY CARE CAPABILITIES.—

(1) IN GENERAL.—Section 1859 of such Act (42 U.S.C. 1395w–28) is further amended—

(A) in subsection (b)(6)(A), as amended by subsection (a)(1)—

(i) by striking "and" at the end of clause (i);

(ii) by striking the period at the end of clause (ii) and inserting "; and" ; and

(iii) by adding at the end the following new clause:

"(iii) meets the applicable requirements specified in subsection (f) for the plan."; and

(B) in subsection (f)—

(i) by amending the heading to read as follows: "REQUIREMENTS FOR ENROLLMENT IN SPECIALIZED MA PLANS FOR SPECIAL NEEDS BENEFICIARIES";

(ii) by designating the sentence beginning "In the case of" as paragraph (1)

with the heading "REQUIREMENTS FOR ENROLLMENT.—" and with appropriate indentation; and

(iii) by adding at the end the following new paragraphs:

"(2) ADDITIONAL REQUIREMENTS FOR DUAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(A)(ii)(II), the applicable requirements of this subsection include the following:

"(A)(i) Subject to clause (ii), the plan has an agreement with the State Medicaid agency that—

"(I) includes provisions regarding cooperation on the coordination of care and the coordination of the financing of care for such individuals;

"(II) includes a description of any Medicaid services to be covered by the plan for individuals enrolled in the plan eligible under such title for medical assistance;

"(III) includes a description of the manner that the State Medicaid program under title XIX will fulfill its responsibilities under such title (including section

1902) with respect to payment for Medicare cost-sharing and with respect to payment for any Medicaid services not covered by Medicare for individuals enrolled in the plan eligible under such title for medical assistance; and

"(IV) requires the disclosure to enrollees, including in the marketing materials of such plan, of Medicaid benefits and of those provider networks that contract with the State under the Medicaid program.

"(ii) The agreement requirement of clause (i) between a plan and a State Medicaid agency shall not apply if the Secretary determines that the State—

"(I) does not have the administrative infrastructure to enter into such agreements with such plan or to provide for coordination of benefits or payments with such plans;

"(II) is unable to enter into such an agreement because of a State limitation on the number of Medicaid managed care contracts issued; or

"(III) is otherwise unwilling or unable to enter into such an agreement.

"(B) The out-of-pocket costs for services under parts A and B that are charged to enrollees may not exceed the out-of-pocket costs for same services permitted for such individuals under title XIX.

"(3) ADDITIONAL REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(A)(ii)(III), the applicable requirements of this subsection include the following:

"(A) The plan is designated to serve, and serves, individuals described in subsection (b)(6)(1)(B)(iii).

"(B) The plan meets any of the 3 following criteria:

"(i) The plan specializes in care of individuals who are disabled or have end-stage renal disease, including individuals who are eligible for benefits under part A through the application of section 226(b) or section 226A.

"(ii) The plan specializes in care for persons who have co-morbid or complex chronic conditions that influence other aspects of health and have a high risk of hospitalization or other significant adverse health outcomes.

"(iii) The plan has an average risk score under section 1853(a)(1)(C) of 1.35 or greater.

"(4) COMPLEX CARE MANAGEMENT CAPABILITIES FOR ALL SNPS.—The complex care management capabilities for a specialized need plan shall include with respect to a special needs individual enrolled under the plan the following:

"(A) Conducting an initial assessment, and annual reassessment, of the individual's physical, social, medical, and functional needs for each individual enrolled in the plan.

"(B) Developing, for each such individual and with input of the individual, an individualized plan of care that identifies goals and objectives, including measurable outcomes.

"(C) Using an interdisciplinary team in management of care and assuring appropriate access to specialty care networks.

"(D) Developing interventions based on population-based protocols and best practices to the extent available.

"(E) Assigning appropriate clinicians to meet the unique needs of the population being served.

"(F) Assuring coordination among clinicians and other service providers involved.

"(G) Assisting individuals enrolled in the plan who are entitled to medical assistance under title XIX in accessing and coordinating benefits and services under this title and under such title.

"(5) SPECIALTY CARE NETWORK DEFINED.—In this subsection, the term 'specialty care network' means, with respect to a specialized need plan, a group of health care providers under contract with the plan that—

"(A) includes physicians, hospitals, nursing facilities, and allied health and social service providers with special expertise relevant to the special needs population being served;

"(B) serves a common chronically ill or impaired population, either at the same time or in sequence to one another; and

"(C) work together to improve total quality and cost performance.".

(2) QUALITY STANDARDS AND QUALITY REPORTING.—Section 1852(e)(3) of such Act (42 U.S.C. 1395w–22(e)(3)) is amended—

(A) in subparagraph (A)(i), by adding at the end the following: "In the case of a specialized MA plan for special needs individuals, the organization shall provide for the reporting on quality measures developed for the plan under subparagraph (C)."; and

(B) by adding at the end the following new subparagraph:

"(C) SPECIFICATION OF QUALITY MEASUREMENTS FOR SPECIALIZED MA PLANS.—

"(i) IN GENERAL.—Notwithstanding subparagraph (B), the Secretary shall specify quality measures appropriate to meeting the needs of beneficiaries enrolled in specialized MA plans for special needs individuals (described in section 1859(b)(6)(A)). In implementing such measures, the Secretary shall take into account those HEDIS measures and structure and process measures identified that

are unique to special needs individuals enrolled under such plans.

"(ii) SATISFACTION THROUGH CURRENT REPORTING REQUIREMENTS.—Nothing in clause (i) shall be construed as requiring the Secretary to impose on specialized MA plans for special needs individuals requirements that are in addition to the reporting requirements that are imposed on such plans as of the date of the enactment of this subparagraph. In implementing such clause, the Secretary shall not require the reporting by such plans of measures under such clause in a manner that is more burdensome to such plans than the reporting burden imposed on other MA plans.".

(c) EFFECTIVE DATE; GRANDFATHER; TRANSITION.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided, the amendments made by this section shall take effect for enrollments occurring on or after January 1, 2010.

(B) MEDICAID CONTRACT REQUIREMENT.—Section 1859(f)(2)(A) of the Social Security Act, as added by subsection (b)(1)(B)(iii), shall apply to plan years beginning on or after the date that is 3 years after the date of the enactment of this Act.

(2) PERMITTING MAINTENANCE OF POLICIES AND PROCEDURES FOR CURRENT DUAL-ELIGIBLE SNPS UNDER A STATE INTEGRATION PROGRAM.—In the case of a specialized MA plan for special needs individuals described in section 1859(b)(6)(A)(ii)(II)) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(A)(ii)(II)) that is offered under a State Medicaid Integrated Medicare-Medicaid Program that was approved by the Administrator of the Centers for Medicaid & Medicare Services before the date of the enactment of this Act, and expansions of such a Program offered on or after such date, the Secretary of Health and Human Services shall permit the continuation of policies and procedures in effect under such a Program as of the date of the enactment of this Act notwithstanding the amendments made by this section.

(3) ORDERLY TRANSITION FOR CERTAIN ENROLLEES.—The Secretary of Health and Human

Services shall provide for an orderly transition of those specialized MA plans for special needs individuals (as defined in subparagraph (A) of section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)), as of the date of the enactment of this Act), and their enrollees, that no longer qualify as such plans or as such individuals under such section, as amended by this section.

SEC. 4. STUDY ON IMPROVING RISK ADJUSTMENT FOR HIGH-RISK, HIGH-COST BENEFICIARIES.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that evaluates the adequacy of the Medicare Advantage risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)), as well as the risk adjustment mechanism under section 1860D–15(c)(1)(A) of such Act (42 U.S.C. 1395w–115(c)(1)(A)).

(b) PARTICULARS.—The report under subsection (a) shall include an evaluation of the need for improving the adequacy of the existing hierarchical condition categories and pharmacy risk adjustment methods for plans that specialize in care of high-risk beneficiaries as it relates to—

(1) accurately predicting costs for beneficiaries with—

(A) sustained high-risk scores over multiple contract periods;

(B) high costs;

(C) co-morbid chronic conditions;

(D) diagnoses not included in the risk-adjustment methodology, including dementia and other cognitive impairments;

(E) physical disabilities, developmental disabilities, or both; and

(F) frailty;

(2) including further gradations of diseases and conditions to better reflect stage of condition, condition severity and costs related to burden of illness;

(3) accounting for costs of pre-existing conditions at the time of initial enrollment for new entrants to the Medicare program; and

(4) enhancing coding persistency by calculating risk scores using data covering at least two years.

(c) REFINEMENT.—The Secretary shall refine the risk-adjusted payment methods referred to in subsection (a) for high-risk, high-cost beneficiaries, consistent with the results of the study, not later than 2 years after the date of the enactment of this Act.

SEC. 5. ADVANCE ALIGNMENT OF MEDICARE AND MEDICAID FOR DUAL ELIGIBLES.

(a) ALIGNMENT OF MEDICARE AND MEDICAID POLICIES AND PROCEDURES FOR SNPS SERVING DUAL ELIGIBLES.—In order to increase simplicity for dual eligibles in accessing and coordinating Medicare and Medicaid benefits by enhancing coordination between CMS and State Medicaid agencies in the oversight of SNPs insofar as they serve dual eligibles, the Secretary may modify rules, policies, and procedures under titles XVIII and XIX of such Act in order to provide for the alignment of Medicare and Medicaid requirements, including marketing, enrollment, care coordination, auditing, reporting, quality assurance, and other relevant oversight functions.

(b) OFFICE OF MEDICARE/MEDICAID INTEGRATION.—

(1) ESTABLISHMENT.—The Secretary shall establish or designate an Office on Medicare/Medicaid Integration (in this subsection referred to as the "Office") for the purpose of aligning Medicare and Medicaid policies and procedures and developing tools to support State integration efforts in order—

(A) to simplify dual eligible access to Medicare and Medicaid benefits and services;

(B) to improve care continuity and ensure safe and effective care transitions;

(C) to eliminate cost shifting between Medicare and Medicaid and among related care providers;

(D) to eliminate regulatory conflicts between Medicare and Medicaid rules; and

(E) to improve total cost and quality performance.

(2) HEAD.—The head of the Office who shall report to the Administrator of the Centers for Medicare & Medicaid Services.

(3) RESPONSIBILITIES.—The responsibilities of the Office are to develop policies and procedures—

(A) to support State efforts to coordinate and align acute and long-term care benefits for dual eligibles through a State plan option or other means;

(B) to provide support for coordination of State and Federal contracting and oversight for dual integration programs supportive of the goals described in paragraph (1); and

(C) to align Federal rules for Medicaid managed care and Medicare Advantage Plans to include methods for integrating marketing, enrollment, grievances and appeals, auditing,

reporting, quality assurance and other relevant oversight functions.

(c) FACILITATION OF ALIGNMENT.—The Secretary shall—

(1) submit to Congress a report on statutory changes needed to facilitate the alignment of Medicare and Medicaid policies for dual eligibles;

(2) work with the Congressional Budget Office and the Office of Management and Budget to establish a process for evaluating total Medicare and Medicaid spending for beneficiaries who are dually eligible for Medicare and Medicaid and enrolled in plans that integrate Medicare and Medicaid benefits such that the enrollment of such beneficiaries in such plans is treated as "budget neutral" if the combined Medicare and Medicaid costs under such plans do not exceed the combined costs of providing Medicare and Medicaid services on a fee-for-service basis for a comparable risk group; and

(3) provide States and SNPs with education and tools for developing programs that align Medicare and Medicaid benefits for dual eligibles.

(d) IDENTIFICATION OF INCENTIVES IN SUPPORT OF STATE INTEGRATION EFFORTS.—The Secretary shall identify incentives for States to advance the development

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of integrated approaches in providing health care services for dual eligibles.

(e) DEFINITIONS.—In this section:

(1) CMS.—The term "CMS" means the Centers for Medicare & Medicaid Services.

(2) DUAL ELIGIBLE.—The term "dual eligible" means an MA eligible individual (as defined in section 1851(a)(3) of the Social Security Act, 42 U.S.C. 13195w–21(a)(3)) who is also entitled to medical assistance under a State plan under title XIX of the Social Security Act.

(3) DUAL ELIGIBLE SNP.—The term "dual eligible SNP" means a SNP described in section 1859(b)(6)(A)(ii)(II) of the Social Security Act, as amended by section 3(a).

(4) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

(5) SNP.—The term "SNP" means a specialized MA plan for special needs individuals, as defined in section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(A)).

(6) STATE.—The term "State" has the meaning given such term for purposes of title XIX of the Social Security Act.

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